Johnson&Johnson MedTech

SHOCKWAVE MEDICAL

2026 PERIPHERAL INTRAVASCULAR LITHOTRIPSY

Hospital and Ambulatory Surgical Center (ASC) Coding Guide

The below information is provided to assist in the accurate coding of Intravascular Lithotripsy (IVL) procedures with Shockwave IVL catheters. IVL is the energy-based generation of ultrasonic acoustic pressure waves for modification, fracture, and fragmentation of vascular calcification.

The coding, coverage, and payment information contained herein is gathered from various resources and is subject to change without notice. Shockwave Medical cannot guarantee success in obtaining third-party insurance payments.

Third-party payment for medical products and services is affected by numerous factors. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that are rendered. Providers should contact their third-party payers for specific information on their coding, coverage, and payment policies.

SHOCKWAVE | IVL

2026 HOSPITAL OUTPATIENT

IVL Hospital Outpatient Ambulatory Payment Classification (APC) Assignment

Hospital outpatient claims must contain the appropriate Healthcare Common Procedure Coding System (HCPCS) Level I and II code(s) to indicate the items and services that are furnished to the patient.

The Centers for Medicare and Medicaid Services (CMS) reimburses hospital outpatient departments using Ambulatory Payment Classification assignments (APCs). For CY 2026, CMS continued to assign eight HCPCS codes that describe peripheral IVL procedures performed in lower extremity arteries to clinical APCs in the hospital outpatient setting. The eight HCPCS codes describe procedures in the iliac, femoral/popliteal and the tibial/peroneal arteries. Payment rate changes are effective January 1, 2026, and represent national payment rates.

The table below contains a list of possible HCPCS codes that may be used to report IVL:

Code*	Description	Status Indicator[1]	2026 APC[2]	2026 Medicare Natl Payment[2]
C9764	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	J1	5193	$11,794
C9765	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	J1	5194	$18,729
C9766	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	J1	5194	$18,729
C9767	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	J1	5194	$18,729
C9772	Revascularization, endovascular, open or percutaneous, tibial/ peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	J1	5193	$11,794
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	J1	5194	$18,729
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	J1	5194	$18,729
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	J1	5194	$18,729

[1] CMS-1834-FC, Addenda B, D1; SI of J1: Comprehensive APC, All covered services on the claim are packaged with the primary "J1" service on the claim.

HCPCS CODES FOR REPORTING PERIPHERAL IVL

HCPCS codes identify devices, items and some services. In addition to reporting the relevant CPT or HCPCS code for the procedure, Medicare and many commercial payers require that hospital outpatient departments also report a C code for the implanted device. The following C code may be appropriate for reporting the peripheral IVL catheter in the hospital outpatient setting:

- C1889 Implantable/insertable device, not otherwise classified

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 24, 2025 but is subject to change without notice. Amounts do not reflect any subsequent changes in payment since publication. To confirm reimbursement rates, you should consult with your local Medicare Administrative Contractor for specific codes.

Providers should select the most appropriate HCPCS code(s) with the highest level of detail to describe the service(s) rendered to the patient. Any questions should be directed to the pertinent local payer.

It is important to note that the C-codes are designed to identify the entire procedure, and not just the IVL catheter, when IVL is performed in revascularization procedures. Hospital and ASC charges for the HCPCS codes should reflect charges for the entire procedure similar to other lower extremity revascularization procedures, including charges associated with the IVL catheter.

Hospital Outpatient Complexity Adjustments for Peripheral IVL

In some cases IVL +Angioplasty procedures when performed in combination with a second endovascular procedure, have a complexity adjustment to a new APC level. This table outlines a few relevant IVL complexity adjustments. Connect with a Shockwave Reimbursement specialist for a complete list or for further information.

Primary Procedure Code	Primary Description	Secondary Procedure Code	Secondary Description	New APC Level
C9764	IVL + PTA Above the Knee	C9764	IVL + PTA Above the Knee*	5194
		C9772	IVL + PTA Below the Knee	5194

*The C9764 + C9764 complexity adjustment applies to bilateral procedures.

2026 Ambulatory Surgery Center (ASC)

The eight IVL procedural C-codes are included on the ASC Covered Procedure List for CY 2026.

The table below contains a list of possible HCPCS codes that may be used to bill for IVL in the ASC setting:

Code	Description	Medicare 2026 National Payment[2]
C9764	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	$8,249
C9765	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	$13,269
C9766	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	$13,628
C9767	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	$13,908
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	$8,000
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	$12,025
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	$13,064
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	$14,121

[2] CMS-1834-FC; Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System Calendar Year 2026 Final Rule Addenda AA, 11242025.

HOSPITAL INPATIENT

Coding: Possible ICD-10-PCS codes for IVL procedures[3]

Hospital inpatient claims must contain the appropriate ICD-10-PCS (procedure) code(s) to indicate the items and services that are furnished to the patient. The table below contains a list of possible ICD 10-PCS codes that may be used to report peripheral IVL in the lower extremities.

Providers should select the most appropriate ICD-10-PCS code(s) with the highest level of detail to describe the service(s) rendered to the patient. Any questions should be directed to the pertinent local payer.

Code	Description
04FC3ZZ	Fragmentation of Right Common Iliac Artery, Percutaneous Approach
04FE3ZZ	Fragmentation of Right Internal Iliac Artery, Percutaneous Approach
04FH3ZZ	Fragmentation of Right External Iliac Artery, Percutaneous Approach
04FK3ZZ	Fragmentation of Right Femoral Artery, Percutaneous Approach
04FM3ZZ	Fragmentation of Right Popliteal Artery, Percutaneous Approach
04FP3ZZ	Fragmentation of Right Anterior Tibial Artery, Percutaneous Approach
04FR3ZZ	Fragmentation of Right Posterior Tibial Artery, Percutaneous Approach
04FT3ZZ	Fragmentation of Right Peroneal Artery, Percutaneous Approach
04FD3ZZ	Fragmentation of Left Common Iliac Artery, Percutaneous Approach
04FF3ZZ	Fragmentation of Left Internal Iliac Artery, Percutaneous Approach
04FJ3ZZ	Fragmentation of Left External Iliac Artery, Percutaneous Approach
04FL3ZZ	Fragmentation of Left Femoral Artery, Percutaneous Approach
04FN3ZZ	Fragmentation of Left Popliteal Artery, Percutaneous Approach
04FQ3ZZ	Fragmentation of Left Anterior Tibial Artery, Percutaneous Approach
04FS3ZZ	Fragmentation of Left Posterior Tibial Artery, Percutaneous Approach
04FU3ZZ	Fragmentation of Left Peroneal Artery, Percutaneous Approach
04FY3ZZ	Fragmentation of Lower Artery, Percutaneous Approach

[3] 2026 ICD-10-PCS: The Complete Official Code Set

Payment: Medicare 2026 Hospital Inpatient MS-DRGs

The Peripheral IVL ICD-10-PCS codes typically group to MS-DRGs 278 and 279. The 2026 rates became effective October 1, 2025. When other procedures are performed in addition to IVL, other MS-DRGs may apply.

MS-DRG	Description	FY2026 Medicare National Base Payment[3]
278	Ultrasound accelerated and other thrombolysis of peripheral vascular structures with MCC	$40,504
279	Ultrasound accelerated and other thrombolysis of peripheral vascular structures without MCC	$26,243

MCC: Major Complications and Comorbidities

[3] National base MS-DRG rates shown are based on CMS-1833-FC, FY 2026 Hospital Inpatient PPS Final Rule, 10012025, Table 1 & Table 5. National base payment rates assume full update amount for hospitals which have submitted quality data and hospitals have a wage index greater than 1. Site specific payment rates will vary based on regional area wage differences, teaching hospital status, indirect medical education costs, quality data, additional payments to hospitals that treat a large percentage of low-income patients ("disproportionate share payments"), etc. MS-DRG payment rates shown do not include sequestration reduction.

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 25, 2025 but is subject to change without notice. Amounts do not reflect any subsequent changes in payment since publication. To confirm reimbursement rates, you should consult with your local Medicare Administrative Contractor (MAC) or other payer.

This document includes possible codes that may be applicable to report the use of a Shockwave peripheral IVL device. Each provider must verify the appropriate codes for each patient. It is the provider's sole responsibility to determine and submit appropriate codes, charges, and modifiers for services rendered. Providers should contact insurers to verify correct coding procedures prior to submitting claims related to IVL. Shockwave Medical cannot guarantee coverage or reimbursement with the codes listed in this billing guide. In all cases, providers will need to follow local payer policies for billing and reimbursement.

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QUESTIONS?

CONTACT YOUR SHOCKWAVE IVL SALES REPRESENTATIVE OR EMAIL **SHOCKWAVEREIMBURSEMENT@ITS.JNJ.COM** TO CONNECT WITH A REIMBURSEMENT SPECIALIST

In the US: Rx Only

Prior to use, please reference the Instructions for Use for more information on indications, contraindications, warnings, precautions, and adverse events. **www.shockwavemedical.com/IFU**

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